PUBLIC CONSULTING GROUP

State of Washington
Department of Social and Health Services
Mental Health Division

PALS Community Placement Assessment

FINAL REPORT

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I. EXECUTIVE SUMMARY

Public Consulting Group, Inc. (PCG) was engaged by the Mental Health Division of the State of Washington Department of Social and Health Services to perform a scope of work entitled the "PALS Community Placement Assessment". The goal of this project was to provide comprehensive information about current long-term residents at PALS (Program for Adaptive Living Skills) and to identify the resources needed to provide the level of care and supports needed to successfully transition to alternative community placements. A total of 101 PALS residents were assessed during this project led by the clinical members of our project team – Paul Barreira, MD and Gail Hanson-Mayer, RN, CS, MPH. The key findings and recommendations of this assessment are as follows:

A. Alternative Community Placement Destinations

1. All but 11 of the 101 PALS residents are ready for alternative community placement. Of the remaining 11 residents, 5 are projected to require inpatient care, 1 resident is projected to require intensive supervision if moved to the community residence (Pierce County), and 5 residents are considered very difficult placements and alternative community placement requires additional individual discussion and is undetermined at this time.

2. Of the 90 PALS residents who are ready for alternative community placement, 9 required some sort of administrative intervention to manage the community placement due to legal issues (significant past criminal histories or to remove restrictions from leaving the grounds of Western State Hospital). Of these 90 residents, 76 will require a community residence, 5 are able to live independently in apartments, 3 are able to live independently at home (with or without family) and 6 will require nursing home care.

3. The distribution of the PALS residents is concentrated in 4 RSNs with King (38 residents), Pierce (25 residents), North Sound (16 residents) and Peninsula (9 residents) accounting for 87% of the total PALS resident population.

B. Service Capacity Issues

1. Additional residential capacity and expanded support services will be needed to meet the increased demand for services that will result from this transition from PALS. Of the 76 residents who are projected to require a community residential placement, 42 residents are recommended for a Generic community residence and 34 are recommended for a Specialized community residence (e.g., Dual Diagnosis, Intensive Supervision, All Male, All Female, Small Program, MI / DD or Forensic).

2. The most immediate need to accomplish this transition, beyond the necessary expansion in residential capacity, is the development of PACT teams to best manage

the needs of the transitioned residents. A total of 48 residents are projected to require the assistance of PACT Teams. In advance of the alternative community placement, case managers will also be required to manage the transition from the PALS program.

3. Subsequent to the development of PACT Teams, additional support services should be expanded or created to support the transition of the PALS residents into the community, including Day Rehab, Social Clubs, Vocational, and Specialized Day Programs. Special Treatment Needs in the areas of Substance Abuse, Neurological / Cognitive Impairment, Forensic Involvement and Medical Issues are also recommended.

C. Program Issues

1. A program to integrate the treatment of Co-Occurring Disorders (Substance Abuse / Mental Illness) through a combination of staff supported housing, PACT / ACT Teams, and flexible support services (including vocational programs) is recommended to more actively engage clients in treatment.

2. Psychosocial Rehabilitation Programs and Community Crisis Based Crisis Services should be expanded to promote recovery and enhance early intervention in situations of relapse or crisis.

D. Implementation Issues

1. The PALS transition is anticipated to be a two-phased activity. Transition Phase I can include the residents who are projected to require less specialized community service needs. Candidates for this initial placement phase can be drawn from the following population subsets:
    a. 42 residents who are in need of Generic (non-specialized) community residences
    b. 6 residents who are in need of nursing home care
    c. 5 residents who can live independently in apartments
    d. 3 residents who are able to live at home (either independently or with family)

2. Transition Phase II can include the remaining residents who require more specialized community service needs or other services such as inpatient care.

3. The cost of the PALS transition is estimated to be $6.9 million per year. This provides an average cost of $187 per day per client, and ranges from $109 to $333 per RSN based on the projected blend of services required for the consumers assigned to each RSN. Case management and physician medication management services for subsets of the population (53 PALS residents not recommended for inclusion in a PACT team) are excluded from this estimate.

II. SUMMARY OF APPROACH AND PALS RESIDENT CLINICAL PROGRAM NEEDS

To attain the goals of this project, PCG conducted a point in time review of the current PALS residents that focused on the clinical assessment of each individual resident with regard to their readiness for alternative community placement and evaluated the clinical and administrative barriers that have prevented access to community services. A comprehensive review of the current PALS medical record, which included relevant portions of the Washington State Hospital inpatient record, a face to face assessment by our consulting psychiatrist, Dr. Paul Barreira, and/or meeting with the attending PALS psychiatrist (Drs. Borland and Nguyen) and information from the PALS treatment team was utilized to gather the information included in this report. Two critical tools were utilized to collect resident specific data during this project – the Clinical Evaluation of Risk and Functioning (CERF) and a Client Survey Form (see Attachment 1 for additional information). The data collected from these two tools were entered into a spreadsheet data base for future reference and analysis.

The PALS program is located on the campus of Western State Hospital and currently provides a valuable service for serious and persistent mentally ill clients. This residential program includes: a twenty four hour staff supervised residential setting, twenty four hour availability of onsite nursing coverage, daily access to psychiatry and medical follow-up, daily programming both on the unit and off the unit and the capacity to intervene quickly if the resident exhibits a change in clinical status that warrants a higher level of care.

The population within the PALS program was found to vary considerably in both the severity of their illness and level of functioning. The level of risk was carefully evaluated with the focus being on the level of supervision required and the ability to exhibit internal controls necessary for placement and to maintain safety within a less structured community based setting. The focus on these three domains led to the recommendations regarding the individual's placement needs in the community.

The results of the review highlighted the following service recommendations for the PALS residents based on current Evidence Based Practices. The current availability and access of community based services were broadly evaluated to meet the needs of this population. These service categories are identified below and are considered critical in order to facilitate the movement of the PALS residents to the community:

1. Access to community residential placements that include onsite staffing ranging from 8-24 hours per day. Recommendations regarding staffing levels were based upon an individual assessment of each client with a focus on the three domains: severity of illness, level of risk and level of functioning.

2. Access to specialized residential programming with an emphasis on the availability and expertise with the treatment of co-occurring disorders, mental illness/substance abuse.

3. Access to Program for Assertive Community Treatment (PACT) Teams to provide a consistent availability of the community based treatment team to engage the client in active treatment and intervene early when there is a change in clinical status.

4. Access to strength based, recovery focused psycho social rehabilitation programs that provide ongoing daily treatment in a community setting.

5. Access to vocational training that included programs for supportive and transitional employment to enable the client to gain independence and promote improved quality of life.

6. Access to Clubhouses and Social Clubs to promote socialization and decrease isolation in the community.

7. Access to statewide secure residential treatment facilities for high risk residents who would require intensive supervision and monitoring in order to maintain community safety.

III. FINDINGS

Five (5) major findings were identified during our review and are as follows:

1. The majority of PALS residents are ready for alternative community placement.

Overall the study found that 80% of the current PALS population is ready for alternative community placements with the caveat that appropriate community based services are available. The remaining 20% of the population are either not clinically ready to be placed in an alternative community placement due to the level of acuity of their illness or there is the need for a higher level of administrative intervention to occur in order for community placement to move forward. Of this 20% approximately half of the residents fall into this category. The closer review of this subset of the population found that, due to the severity of their previous history in the community, careful consideration is needed as to the appropriate placement for these residents in order to ensure community safety standards.

2. There is a high prevalence of PALS residents with Co-Occurring Disorders (Mental Illness / Substance Abuse).

It is striking to note the high percentage of residents with co-occurring disorders in PALS. Approximately 75% of the current residents carried a diagnosis of a major mental illness with a co-occurring substance abuse disorder. Of this population, 25% of the residents were found to be actively engaged in substance use while residing in PALS. Although the PALS program offered group programming that specifically addressed issues related to mental illness and substance abuse for these residents, attendance has been limited and the easy availability and access to substances on or near the hospital campus made it challenging to promote abstinence. PALS staff was cognizant of this issue but have been hampered by their limited skills and experience with treatment intervention for this population.

3. There is a lack of community resources available to treat the PALS population.

A series of meetings were held with the local RSNs to review the specific recommendations in the report database for each PALS resident and to discuss the current availability of community based services. Consistently there was a high percentage of agreement with the recommendations made by the evaluators and the RSNs. This agreement was predicated on the understanding that the levels of services recommended were available in the community. In discussions with the RSNs it was clear that there were several components of the continuum not available and that a reduction in capacity was imminent. The RSNs expressed interest in providing these services as long as appropriate funding resources were made available and there was recognition by MHD that this was necessary in order to absorb these residents in their communities.
The community programs were reviewed in their relationship to the recommendations for the individual residents of PALS and their current available capacity. It was clear from these meetings that there was a serious lack of community based residential programs across all the

RSNs and that there was virtually no access to residential programming with 24 hour staffing onsite. The other major service gap related to the availability of PACT Teams. Except for one county (Peninsula), PACT teams were either not developed or were at total capacity and unable to accept new referrals. Since half of the PALS residents were recommended PACT teams as part of their community placement requirement the need to develop this service is a priority. Other gaps in the service delivery system included: minimal sober house capacity, no access to residential programs that do not require abstinence from alcohol (wet housing), lack of transportation availability for residents to attend programming in the community, an under developed clubhouse system and limited access to vocational services.

Each of the RSNs did report that there was good availability of community based case management services, access to outpatient psychopharmacology and access to primary care physicians for routine medical care.

Of immediate concern is the pending reduction in community based residential beds due to the IMD regulations regarding facility size and the potential closure of a nursing home which has historically accepted patients with major mental illness and concurrent medical issues that cannot be managed in a generic residential setting. These two combined will place a severe strain on already limited resources.

4. There is a need for state-wide planning to develop community based services for individuals with a history of high risk behaviors.

Within the PALS population there is a small number of residents that have a history of high risk behaviors which will prohibit placement within the current available community options. These categories include individuals with a history of fire setting and individuals with a history of exhibiting dangerous sexual behaviors. It is likely that there are additional consumers ready for placement within the state hospital that would fit into these categories as well.

There have been considerable efforts demonstrated on the part of the Community Case Managers to be creative in constructing viable placement options. Even so, there has been minimal movement of these individuals to the community due to liability limitations that are included within the current contractual agreements with residential providers. The small number of individuals within each category makes it cost prohibitive for each RSN to develop individualized programs. There exists an opportunity for the RSNs to work more collaboratively together to figure out a mechanism to solve this problem.

It is the responsibility of the RSN to either develop or contract for a community based program that will provide this resource. Bringing the RSNs together will form a critical mass of consumers large enough to develop expanded programming across RSNs and provide an avenue for the RSNs to work together more. In order to provide cost effective treatment for this subset of consumers these steps are essential to meet this goal in a timely fashion. Several of these PALS residents are long term and have been stable in treatment for many years.

5. There are PALS residents that required ongoing significant medical monitoring.

There is a small subset of PALS residents who exhibit significant medical needs. The range of medical diagnoses include: Dementia due to Traumatic Brain Injury, Diabetes Mellitus, insulin dependent, unstable Seizure Disorders and Chronic Obstructive Pulmonary Disorder. With the availability of 24 hour nursing care in the PALS program these individuals are well managed. Movement to the community would be best accomplished in most cases by placement in a Nursing Home. The lack of access of available nursing homes beds for individuals with psychiatric disorders that exhibit behavioral issues has limited movement to alternative community placement.

IV. BEST PRACTICE LITERARY RESEARCH

Our analysis of the PALS population indicates that the characteristics of this population is consistent with the experience in other states and in the literature with respect to the level of functional impairment, presence of co-occurring substance abuse, and need for an active psychosocial program that aims to assist the individuals to survive and thrive in the community. Furthermore, the experience of repeated hospitalizations, short periods of incarceration, and disruptive community behavior is a common phenomenon with this population. A community based program should be designed to recognize these interruptions in community tenure and provide the ability for individuals to return to stable community housing and programs following a crisis. Finally, the literature is clear that if individuals with these levels of symptoms, co-occurring illnesses, and functional impairment are to succeed in the community, the community programs need to be comprehensive providing all levels of services including crisis intervention, respite beds, intensive case management, stable housing, and access to supported employment. The problem of poor access to community based services that are known to be effective was prominently cited in the mental health report of the Surgeon General. In response to this crisis a national effort has been mounted to improve the quality of public mental health services by promoting interventions with strong empirical support. (U.S. Surgeon General, 2000; Drake et al., Psychiatric Services, 52,179-182, 2001)

Evidence-Based Practice

The Implementing Evidence-Based Practice (EBPs) Project is designed to increase access for people with SMI to empirically supported interventions. The project identified for initial development six empirically supported EBPs: collaborative psychopharmacology, assertive community treatment, family psycho education, supported employment, illness management and recovery skills, and integrated dual disorders treatment. The EBPs project aims to increase access to these services through development of standardized implementation packages. While the EBPs project has only recently begun, it is possible for states to identify the core principles and critical elements of each of the six EBPs with the intent to implement the practice in the community. For example, many states have committed to developing Fountain House Clubhouses while others have developed PACT teams across the state and still others have developed integrated dual diagnosis treatment.

The EBPs most relevant to the PALS population are Assertive Community Treatment, Integrated Dual Disorders Treatment, and Supported Employment. Family Psychoeducation, Illness Management and Recovery, and Collaborative Psychopharmacology are important and seem to exist to some extent in existing programs. Nevertheless, the first three EBPs are essential to successfully move the PALS population into the community. Moreover, it is possible to think about accomplishing the implementation of supported employment and to some extent integrated dual diagnosis treatment through the establishment of PACT teams (Mueser et al, Behavior Modification, vol.27no.3,387-411,2003; see Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders in literature binder).

Assertive Community Treatment

In the 1970's when the discharge of patients from long term institutions led to negative and costly outcomes, including frequent relapses, rehospitalizations, and frequent crisis interventions, a new approach to case management was developed. Assertive Community Treatment (ACT) model involved providing most psychiatric services to consumers in their own natural living environments rather than a clinic. ACT is distinguished from clinical or brokered case management approaches with respect to its low caseload size (typically 10 consumers per clinician compared to 30 or more in traditional case management), provision of services in consumers' natural living settings, direct provision of services, 24-hour coverage, and the sharing of caseloads across clinicians within a team.

Research shows that ACT is effective at reducing hospitalizations, stabilizing housing in the community, reducing symptom severity, improving quality of life, and lowering overall treatment costs. ACT is most beneficial consumers with a history of frequent or long-term hospitalizations, extremely impaired psychosocial functioning requiring daily assistance to live in the community. Growing evidence supports the therapeutic effectiveness of ACT for consumers with co-occurring disorders, particularly when both the substance use abuse and mental health treatment related services were provided directly by the ACT team. Little evidence supports the success of ACT in reducing substance abuse when the substance abuse services are brokered out to other providers and not directly provided by the ACT team. CSAT has published a document that identifies ACT as an exemplary treatment model to help meet the needs of individuals with co-occurring substance abuse disorders and mental disorders. It is hard to imagine that the PALS population can live successfully in the community without a major investment by the state in development of ACT programs.

Co-Occurring Substance Abuse

It is well recognized that co-occurring substance abuse is the most common and clinically significant co-morbid disorder among individuals with serious mental illness. Individuals with this dual disorder are at higher risk for homelessness, violence, incarceration, higher rates of relapse, hospitalizations, and serious medical illnesses (HIV and hepatitis). They do not engage in the traditional delivery of services for each illness, drop out, and remain disconnected from both systems of care. In order to address this issue in people with serious mental illness and substance abuse, integrated dual disorders treatment models were developed. The common characteristics of these models are: same clinicians treat both disorders simultaneously, case management, medications, housing, vocational rehabilitation, and family interventions. In addition, most programs use assertive outreach to engage clients in treatment, motivation-based interventions that recognize the motivational stages through which people progress in the process of changing addictive behaviors. Multiple studies have demonstrated the effectiveness of these models. In the absence of more integrated services for the PALS population who are serious substance abusers, these individuals will continue to be mainly disengaged from treatment and frequent users of emergency services and inpatient beds (see Section I of Reference binder, particularly the first four articles).

One vexing problem is determining the right supportive housing for individuals who are attempting to recover from substance abuse and serious mental illness. The literature is clear that providing services to individuals in housing effects residential stability, improves stability in both psychiatric and substance abuse symptoms, and reduces the costs of homelessness to the community. Yet, matching an individual to the right housing arrangement requires attention to a number of variables. Individuals with serious mental illness do better initially in staffed supported housing. The level of staffing is usually determined by the level of impairment in attending to daily activities and ability to self-medicate. For individuals with co-occurring substance abuse who may have been homeless, flexible supportive services that are not a requirement to maintain housing is essential. This is especially true for individuals who continue to use substances and the treatment team's activity is focused on engagement. Studies have shown that service-enriched housing reduced housing and service costs compared to control group who did not receive intensive services. In addition, individuals enrolled in such programs had marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated.

Vocational Services

Research consistently shows that individuals with serious mental illness are able to gain employment in natural working settings with the right support. While most of these jobs are entry level, unskilled positions and individuals may work on average 6-12 months per job, the sense of self-esteem increases, the use of intensive crisis services decreases, and the tenure in community settings is longer. The rates for supported employment programs averages 58% compared to 21% for those individuals who receive traditional vocational approaches. Supported employment approaches are in contrast to traditional vocational services that use extensive pre-employment experiences, such as assessment, skills training, counseling, sheltered work experiences, and work trials, prior to placement in a competitive job. Individuals are likely to become stuck in prevocational activities and never make the transition to competitive employment. The addition of a vocational rehabilitation specialist to an ACT team can accomplish the same rate of supported employment (see literature binder Section II, particularly Mueser et al, Implementing Evidence-Based Practices for People with Severe Mental Illness). A number of articles have addressed the costs of community- based services for a population who have been served in an institutional setting for long periods of time. Most of these studies report that the initial costs of providing community based services can be more than the costs for institutional care when adjusted for costs for supporting large buildings.

Funding Considerations

There are many articles that taken together suggest that the failure of community based initiatives can be explained in large part by the lack of funding to develop the necessary services to successfully support individuals with serious mental illness in the community. Some research suggests that the cost offsets in earned income, reduced use of high costs services, and quality of life issues have not been adequately addressed. The ACT model has been studied extensively in this regard. The conclusion is that the costs of running an ACT program can be justified if one looks at the reduction in high costs services used by individuals prior to joining the ACT team.

(Lamb H.R., Bachrach L.L., Psychiatric Services, 52,8,1039-1045, 2001; Rothbard et al., Am J Psychiatry, 155,4, 523-529,1998; Fisher et al., Psychiatric Services, 52,8,1051-1058, 2001)

V. RECOMMENDATIONS

Based on our findings we put forth eight major recommendations with priority focus being placed on the first three recommendations in order to meet the goal of closing the PALS program by 2005.

1. Expansion of Community Based Residential Programs.

It is clear from interviews with the RSNs that the current community based residential services are at or near capacity and that there were major gaps in the available service delivery system that limits the ability of the community providers to safely accept the current PALS residents in the immediate time period. In order to succeed with the goal of reducing the number of beds in PALS by December 1, 2004 and to proceed with the closure of PALS in the year 2005 a careful strategic plan for the development of community based residential treatment services to meet the needs of this population needs to start immediately. We recommend that the emphasis be on the establishment of residential programs that would have the capability of providing staff supervision varying from eight to twenty-four hours per day. It is also of primary importance that a determination of the current residential bed capacity be understood and what impact the implementation of the IMD regulations will have in the near future. There is potentially a more immediate issue with the current community based residents losing their housing due to program closure. In reviewing the current PALS population, our record review and individual interviews determined that 77 of the 101 residents would be best served with residential placement as a transition from PALS to the community. The majority of these residents would benefit from a generic setting that provided support and access to outpatient care.

Our recommendations include three suggested levels for daily onsite staffing requirements. These include:

> **24-hour 4:1 staffing** ratio – this is a residential program with staff available onsite twenty four hours per day at a ratio of 4 residents to one staff member. The responsibility of the staff member is to provide support, monitor compliance with medications, report to case manager any significant changes in clinical status and assist with ADLs. This setting is for individuals who require close monitoring and may pose a safety risk. A total of 38 PALS residents (49% of the 77 residents who were projected to need a community residence) were projected to require this level of staffing.
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> **6-23 hours staffing** per day – this residential setting provides for one staff member available onsite from a range of six to twenty three hours per day. These settings generally are structured to provide either sixteen or eight hours of onsite coverage. Residents in these settings are able to manage more independently and require less supervision. A total of 35 PALS residents (45% of the 77 residents who were projected to need a community residence) were projected to require this level of staffing.
>
> **1-5 hours staffing** per day – this setting provides minimal daily onsite staffing. The focus is primarily on monitoring medication compliance and providing support. Care

coordination is provided by the community case manager. Only 1 PALS resident was projected to require this level of staffing. The remaining 3 PALS residents were projected to require less than daily staffing.

2. Development of PACT Teams

Program for Assertive Community Treatment (PACT) has been proven as an effective Evidenced Based Practice treatment model for seriously mentally ill individuals with substance abuse disorders who frequently get embroiled in the legal system and are high utilizers of inpatient services. This population has been shown to respond more positively and successfully to treatment that is provided outside the traditional office or clinic setting.

Our experience in developing PACT Teams has demonstrated that the recruitment and development of each team takes considerable time. It will be important for each discipline within the PACT teams to be cross-trained in providing treatment for consumers with serious mental illness and substance abuse. Modifications to the PACT team model are at times utilized to meet the needs of rural settings and settings where access to qualified staff is limited. The literature has reported that the truer one stays to the original PACT model the greater the chance of positive treatment outcomes.

Of the 101 current PALS residents reviewed, 48 were recommended for a PACT Team. The distribution of current PALS residents across RSNs that will require additional PACT Team services to accommodate our recommendation**s** are the following: (16) Pierce, (14) King, (10) North Sound, (4) Peninsula and (1) each for Southwest, Thurston-Mason and Timberland. This distribution allows for there to be focused development in selected RSNs to meet this need. With the optimal ratio for an urban setting of 50 consumers to 1 PACT team within which 10 consumers are assigned to 1 case manager (8 to 1 ratio for rural settings), there is an immediate need to develop at least one PACT Team to serve the residents from Pierce RSN (serving 16 PALS residents) and King RSN (serving 14 PALS residents)**.** As this model of treatment is labor intensive and initially requires significant ramp up costs, sharing of resources within large geographic regions provides an economy of scale without compromising clinical standards. Our discussions with the RSNs have provided us with the information that presently there were only limited PACT Team services available across the state.

Another 2 PACT teams are also recommended to serve the residents from North Sound (serving 10 PALS residents) and Peninsula (serving 4 PALS residents). Sharing across these two RSNs is more challenging due to their geographical size, but may still be considered. However, the creation of two teams will also provide the opportunity to serve others consumers beyond the current PALS residents in a cost effective manner. Examples of others to be served include individuals who are being discharged into the community from inpatient hospital stays and community-based consumers in crisis,

3. Development of specialized residential and treatment services for Co-Occurring Disorders.

The high prevalence of consumers with co-occurring disorders requires that appropriate treatment services are available in the community in order to reduce the potential for relapse which may result in rehospitalization. There are three categories of needs under this umbrella. Consumers with co-occurring mental illness/substance abuse, consumers with co-occurring mental illness/developmental disabilities and consumers with co-occurring mental illness/medical comorbidity. There is some overlap within these categories with regard to the current PALS residents. The current services available in the community are typically not geared to manage these dual issues well. The available expertise tends to focus on treating one disorder instead of addressing both simultaneously. Current Evidenced Based Practice recommends that at all levels of treatment the consumer's co-occurring disorder be addressed. Development of these services is essential to maintain these residents in the community over the long-term. Residential staff should be cross-trained in providing treatment for co-occurring disorders within the community setting.

4. Development of a regional planning strategy for implementation of Specialized Residential Treatment Programs (Sexual Predators, Fire Setters, Forensics)

Based on the data reviewed it is critical to initiate the development of a regional approach across RSNs for developing specialized residential treatment services that addresses the limited number of individuals for whom the barriers to residential placement prohibit their placement in the more traditional settings. These residents have a history of fire setting, exhibiting dangerous sexual behaviors or other forensic involvement. The current PALS residents in these categories are spread across the Regional Support Networks. It is recommended that there be a joining together of the Regional Support Networks statewide providers to address community based program development.

Due to the small number of individuals identified in each region, this approach will increase the feasibility of program development by sharing the allocation of valuable local resources to accomplish a broader statewide effort. These specialized residential facilities would provide increased security to promote and ensure that community safety standards are met. In our meetings with the RSNs we learned that the community providers were resistant to housing these individuals due to concerns regarding increased liability and the need to ensure community safety. Support is needed at an administrative level to address this liability concern. Plans for developing a shared risk liability methodology should be explored.

5. Development of expanded Psychosocial Rehabilitation Programs (PSR)

Psychosocial Rehabilitation Services (PSR) provides consumers with the opportunity to develop skills in a patient centered environment that is strength based and promotes recovery. This concept is geared toward improving the quality of life for consumers. The PALS residents

currently are provided with programming activity to foster these goals but were observed to generally not participate actively in their treatment. The PALS treatment program exhibited more of a care taking atmosphere rather than promoting independence and taking responsibility to achieve recovery goals. It appeared that there was no fundamental expectation that this would occur. In order to live successfully in the community, consumer's will need to develop the tools necessary to be able to make decisions with less supervision and will require skills training on an ongoing basis to achieve their recovery goals. Psychosocial programming includes a variety of community based services such as day treatment programs, social clubs and clubhouses, vocational training, supportive employment opportunity and peer specialist training. These programs were found to be either limited in scope or availability.

6. System-wide training for Co-Occurring Disorders

Seventy-five percent of the PALS residents had an identified co-occurring disorder upon record review. Of this population at least one quarter were actively using drugs or alcohol while in residential placement at PALS. The staff were lacking in training for the treatment of co-occurring disorders and often felt ill equipped to know how to intervene. Based on the characteristics of this population one can surmise that it is likely that there are a high number of consumers with co-occurring disorders currently residing in the community. In order to provide appropriate services for this prevalent population these is a need for system wide training to make treatment of co-occurring disorders within MHD the expectation not the exception and to promote the message that all staff need to be cross trained in order to be effective clinicians within the MHD system of care. The Division should consider engaging expertise in this area to devise a strategic plan for system-wide training that encompasses all levels of the service delivery system.

7. Expansion of existing Community Based Crisis Services

The community safety net for consumers in crisis or at risk for relapse of their illness revolves around the provision of high quality and easily accessible psychiatric emergency services. Most crises can be averted from escalating into a more serious event with early intervention and crisis management support (the goal being to prevent lengthy State Hospitalization). When consumers and local providers are assured that crisis support is available there is greater ability for the community to manage more acute or seriously ill individuals. The services currently available in the community are limited in their ability to develop creative crisis management plans to provide stabilization and divert from hospitalization. Regions with Evaluation & Treatment Programs have a greater capacity to manage crisis situations in the community. These beds are limited and are not geographically dispersed. An expansion of this service is recommended to provide each region the opportunity to develop greater crisis management capacity at the local/community level.

8. Foster Interagency Collaboration (Developmental Disabilities, Substance Abuse)

Due to high numbers of PALS residents with co-occurring disorders, it is recommended that there be a continued emphasis on fostering enhanced interagency collaboration in order to assist with the development of appropriate community based programs. There is an opportunity to create blended interagency funding mechanisms which would specifically address the residential and treatment needs for these populations. Leadership is needed at the Division level to develop joint interagency agreements that focus on developing creative strategies for implementation of community based programs for these specialty populations.

VI. IMPLEMENTATION STRATEGIES

Upon review of the PALS residents and review of the current community based service system it is our opinion that Phase I of this transition will be achievable. The residents recommended for placement in a generic residential setting, apartment or nursing home are ready to move now. This accounts for at least half of the current PALS residents. Prioritization of available community resources needs to occur in each RSN as soon as possible with the goal to develop a plan to accommodate the transition of this first group. As stated earlier, clarity around current residential resources is essential in order to plan for the development of these services. The development of additional residential bed capacity needs to commence in order to be prepared to meet the timeline for closure of PALS beds.

It is recommended that the focus of Phase I transition be on the development of residential bed capacity and PACT Teams in each RSN. The additional day programming and vocational training can be phased in once the residents are securely placed and have transitioned off WSH grounds. The availability of a Case Manager for each PALS Resident is also essential to ensure success. Case Managers should be assigned a minimum of three months prior to the scheduled move. During this three month period the optimum plan would be for regular contact with the PALS resident to occur.

The breakdown of residential beds needed to accommodate the first phase of bed closure is the following:

1. 42 residents who are in need of Generic (non-specialized) community residences
   - 18 of these 42 residents are in need of PACT Teams services
2. 6 residents who are in need of nursing home care
   - no PACT Team services required
3. 5 residents who can live independently in apartments
   - 4 of these residents are in need of PACT Teams services
4. 3 residents who are able to live at home (either independently or with family)
   - all required PACT Team services

The total number of residents who requires PACT Teams services is projected to be 25 during the first phase. They are distributed among the RSNs as follows:

Pierce	7 Residents
King	6
North Sound	6
Peninsula	3
Clark	1
Grays Harbor	1
Thurston – Mason	1
Total	25 Residents

VII. ACKNOWLEDGEMENTS

PCG would like to acknowledge the high degree of cooperation that was provided throughout the duration of this project and to thank all those involved. This openness enabled PCG to better define the clinical care needs of the PALS residents and to identify the various types of obstacles that have served as barriers to their placement to the Community. Key contributors to the findings, conclusions, and recommendations that have been included in this report include the following:

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Western State Hospital (Benefits, Entitlements & Medical Insurance Data)

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John Alspaw	Admissions Coordinator

Residential Support Networks (RSNs)

June 2, 2004 RSN Meeting (Grays Harbor, Clark, Thurston-Mason, Timberlands, Southwest)

Beng Ligasan
Richard G. Peterson
Jaryl O'Connor
Ann Edington
Heidi Williams
Ann Rockway
Janice Larson
Noelle Nelson
Jim Miller
Becky Kellas

June 2, 2004 RSN Meeting (Peninsula)

Beth Friedman Darner
Sue Bunn
Bea Dixon

June 3, 2004 RSN Meeting (North Sound)

Barb McFadden
Marilyn Baker
Mike Watson
Linda Ford
Santiago Iscoa
Debbie Page
Kenny Tam
Lauren (Lake Whatcom Center)
Sandee Engels
Nancy Jones

June 4, 2004 RSN Meeting (Pierce)

Dixie Sanders-Ross
Dave Stewart
Lisa Kleiner
Laura Stansbury
Kent Beatty
Wade Walter
S. Troy Christensen
Stephen Greene
Larry Sorenson
Fran Lewis

June 4, 2004 RSN Meeting (King)

Amnon Shoenfeld
Margaret Smith
Shelle Crosby
Barbara Vannatter
Sylvia Young
Jean Robertson

VIII. ATTACHMENTS

ATTACHMENT 1: *Resident Data Collection and Validation Process*

To complete the goals of the PALS Community Placement Assessment project, PCG developed a work plan to collect the needed information to make accurate clinical assessments and to develop informed conclusions and recommendations regarding how to best meet the clinical needs of each individual PALS (Program for Adaptive Living Skills) resident at an alternative setting. This process consisted of three major activities:

1. Medical record review for each individual PALS resident
2. Validation of medical record review data with PALS direct caregivers
3. Meetings with RSN representatives to validate PAL residents needs and the capacity to delivery needed services

A brief description of each of these major activities is provided in the following sections.

Medical Record Review

The Medical Record review consisted of a two step process:

1. Initial clinical discussion with PALS Psychiatrists Dr. Borland and Dr. Nguyen to obtain their input on each resident. Their input included a brief review of each resident's historical and current clinical status, a suggested suitable alternative placement, and an estimated length of time when the resident might be ready to move to the alternative community placement or other most appropriate and least restrictive setting for the resident.

2. A review of the medical record to identify historical and current clinical status. Two tools were used to record the pertinent clinical data:

    a. Clinical Evaluation of Risk and Functioning (CERF) – A tool that provides:
        i. the current abilities and risks that apply to each individual resident in 15 different areas;
        ii. clinical conclusions regarding
            1. dangerous behaviors (levels of concern that there will be dangerous behaviors in the next 12 months),
            2. behavioral inconsistencies (level of concern about predictability of behavior),
            3. and self-supervision (ability to self-supervise);
        iii. clinical conclusions regarding the level of care needed now and in 6 months based on the least restrictive setting to meet the residents needs;
        iv. recommendations for essential services for the alternative placement of the

resident based on all clinical information collected, including *Residential Needs* based on staffing, supported with *Day Activities / Programs* (primarily social clubs, vocational programs, day rehab, and day treatment) and other *Special Treatment Needs* in the areas of Substance Abuse, Neurological / Cognitive Impairment, Forensic Risk, and Medical Issues.

b. Client Survey Form – a tool that collects pertinent demographic, medical (physical health and psychiatric health and behavior including diagnostic and behavior), benefit entitlement and medical insurance data. This survey form included a section to identify if a set of specific behaviors (such as attempted suicide, drug abuse, fire setting, sexual assault, and use of weapons) occurred either within the last 30 days or anytime in the past.

The information collected using the CERF and the Client Survey Form was recorded in an electronic spreadsheet for future reference and analysis.

Validation of Medical Record Review Data

To validate the clinical findings and conclusions developed for each of the PALS resident, PCG requested that the primary caregivers of each resident complete the CERF. To facilitate a consistent and accurate reflection of the resident's clinical situation, PCG conducted two separate training sessions for PALS caregivers regarding the CERF. The training sessions provided a detailed overview of the tool, explained the purpose of the tool, and answered all specific questions. Subsequent to the training session, the PALS staff with the most direct knowledge of each individual resident prepared the CERF. PCG compared the PALS prepared CERF with the ones prepared from our own review of the medical record. Any significant variances were clarified through discussion with Dr. Borland, Dr. Nguyen, and with the other PALS staff members until a consistent clinical status was attained.

In addition to the above, PCG conducted individual interviews with 58 (or 57%) of the 101 PALS residents to further validate the medical record review and to ensure an accurate assessment of the clinical status of the resident. These interviews were conducted by the PCG Psychiatrist accompanied by the assigned PALS Psychiatrist.

The results of the multiple data gathering methodologies (medical record review, discussions with PALS Psychiatrist, and input via the CERFs prepared by the PALS caregiver staff) combined to provide the most accurate depiction of the clinical status and service needs of each individual PALS resident.

Meetings with RSN Representatives to Validate Resident Needs and Evaluate Capacity to Deliver Needed Services

Multiple meetings were held with the RSNs to review the findings of the clinical status of each PALS resident and the recommended service needs of each resident during the first week of June 2004. To facilitate these meetings, RSN specific reports were generated from the data base of information assembled from the CERFs, the Client Survey Tool, and resident interviews. With only a few exceptions, the clinical status of each individual PALS resident were validated. In the case of these exceptions, additional discussions regarding the resident's clinical status were held until an accurate representation was attained.

ATTACHMENT 2: ***PALS Resident Alternative Community Placement Status Summary***

STATE OF WASHINGTON

PALS RESIDENT ALTERNATIVE COMMUNITY PLACEMENT (ACP) STATUS SUMMARY

RSN	Ready for ACP	Ready for ACP - Need Admin	Not Ready for ACP	Total
Clark	1	-	-	1
Grays Harbor	1	-	1	2
King	30	4	4	38
North Sound	13	1	2	16
Peninsula	8	-	1	9
Pierce	20	2	3	25
Southwest / Cowlitz	1	1	-	2
Spokane	1	-	-	1
Thurston - Mason	3		-	3
Timberlands	3	1	-	4
All RSNs	***81***	***9***	***11***	***101***
Percent of Total	***80%***	***9%***	***11%***	***100%***

ATTACHMENT 3: ***PALS Resident Alternative Community Placement Residence Need Summary***

STATE OF WASHINGTON

PALS RESIDENTS ALTERNATIVE COMMUNITY PLACEMENT (ACP) RESIDENCE NEED SUMMARY

RSN	Geriatric Community Placement		Specialized Community Placement		Apartment, Home, Nursing Home		Inpatient Program / To Be Determined		Total	
	Res.	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*
Clark	1	-	-	-	-	-	-	-	1	-
Grays Harbor	-	-	-	-	1	1	1	-	2	1
King	18	5	11	8	5	1	4	-	38	14
North Sound	6	4	6	4	2	2	2	-	16	10
Peninsula	3	2	1	1	4	1	1	-	9	4
Pierce	9	5	12	9	2	2	2	-	25	16
Southwest / Cowlitz	2	1	-	-	-	-	-	-	2	1
Spokane	1	-	-	-	-	-	-	-	1	-
Thurston - Mason	1	1	2	-	-	-	-	-	3	1
Timberlands	1	-	3	1	-	-	-	-	4	1
All RSNs	***42***	***18***	***35***	***23***	***14***	***7***	***10***	***-***	***101***	***48***
Percent of Total	***42%***	***38%***	***35%***	***48%***	***14%***	***15%***	***10%***	***0%***	***100%***	***100%***

ATTACHMENT 4: *PALS Resident Key Identifiers*

STATE OF WASHINGTON

PALS RESIDENT KEY IDENTIFIERS

RSN	Active Substance Abusers	Co-Occurring SA/MI Disorder History	Fire Setter History	Sexual Predatory Behavior Risk	Sexual Predatory Placement Recommendation	Sexual Predatory PACT Team
Clark	-	1	-	-	-	
Grays Harbor	1	1	-	-	-	
King	5	25	7	1	Inpatient Program	-
North Sound	3	12	4	1	To Be Determined	-
Peninsula	3	7	-	-	-	-
Pierce	6	22	3	2	Home (1), All Male (1)	2
Southwest / Cowlitz	-	2	-	-	-	-
Spokane	-	-	1	-	-	-
Thurston - Mason	1	3	2	1	All Male	-
Timberlands	1	3	-	2	All Male (2)	-
All RSNs	***20***	***76***	***17***	***7***	-	***2***
Percent of Total	***20%***	***75%***	***17%***	***7%***	-	***2%***

ATTACHMENT 5: ***PALS Residents with Fire Setter Histories***

STATE OF WASHINGTON
PALS RESIDENTS WITH FIRE SETTER HISTORIES

RSN	Generic Community Placement		Specialized Community Placement		Apartment, Home, Nursing Home		Inpatient Program / To Be Determined		Total	
	Res.	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*	*Res.*	*PACT*
Clark	-	-	-	-	-	-	-	-	-	-
Grays Harbor	-	-	-	-	-	-	-	-	-	-
King	4	1	2	2	1	-	-	-	7	3
North Sound	2	1	2	-	-	-	-	-	4	1
Peninsula	-	-	-	-	-	-	-	-	-	-
Pierce	-	-	1	1	1	1	1	-	3	2
Southwest / Cowlitz	-	-	-	-	-	-	-	-	-	-
Spokane	1	-	-	-	-	-	-	-	1	-
Thurston - Mason	-	-	1	-	-	-	-	-	1	-
Timberlands	-	-	-	-	-	-	-	-	-	-
All RSNs	***7***	***2***	***6***	***3***	***2***	***1***	***1***	***-***	***16***	***6***
Percent of Total	***7%***	***4%***	***6%***	***6%***	***2%***	***2%***	***1%***	***0%***	***16%***	***13%***

Note: Excludes one resident with fire setter history due to over-riding sexual predatory behavior history.